A Country in Crisis: Launching a County/State Collaborative Forensic Mental Health Team—An Enhancement of the Sequential Intercept Model

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What's good for our mental health inmates is good for us all!

Has your jail or holding facility become the quasi mental health facility for your jurisdiction? Ours certainly has. The Washoe County Sheriff's Office Detention Center, not unlike the majority of detention centers around the country, currently houses more mental health inmates than the Nevada State Psychiatric Hospital has patients.

Our primary mission as correctional facilities and correctional officers is the "care and custody" of those in our facilities. The burning question is, what are we as a profession doing to provide necessary mental health treatment, and how can we help our inmates bypass the revolving door this group invariably finds itself in?

Our mentally ill inmates show a pattern of poor health habits, an inability or unwillingness to take prescribed psychiatric medications, lack of shelter, and an inability or unwillingness to focus on their own treatment—all of which contribute to their perpetual reintroduction into the criminal justice system.

The answers to these questions seem easy: teach these inmates to live healthy lives, remind them to take their medications, give them a home, and help them understand why they need to take an active role in their own well-being, and they will stay out of our jails. However, anyone who has been in law enforcement for any length of time realizes that this is far easier said than done.

Knowing what the answers are, the monumental task that faces us all is figuring out how we implement these fixes without substantially impacting our operations and those of our partner agencies or unnecessarily burdening our communities.

Being Ready When Opportunity Knocks

For some time, The Washoe County Sheriff's Office has been successfully utilizing a program-specific style of management of our mentally ill inmates, with the goal of providing a stable environment within our Detention Center. We were lucky—for lack of a better term—that the Nevada State Medical

Department as well as the Washoe County Sheriff's Office had experienced the lack of sufficient mental health/custody services, and that independently each was searching for a better way.

A purely accidental meeting between this author and the Nevada State Medical Director, Dr. Tracy Green, began the discussions that would soon become the innovative and effective system we now have in place—now named the Forensic Mental Health Team (FMHT). Dr. Green communicated the state's desire to partner with law enforcement in northern Nevada to identify the roadblocks that were hindering the continuity of care that we both knew was needed. I communicated the exponential growth in the mental health community within our detention center over the past 20-plus years, the programs already in place, and what law enforcement perceived as the roadblocks from our perspective. Not surprisingly, the roadblocks each agency encountered either overlapped or were the same.

If our communities knew that law enforcement is on the front line of mental health treatment, they would understand what we have known for a very long time: that our system, although well intentioned, is not only misplaced but largely ineffective. Taxpayers have been unknowingly throwing good money after bad to fund mental health care that is marginally effective at best. Law enforcement knows that the answers must lie with our ability to introduce mentally ill community members to, and keep them within, a structured mental health program. The trick is to get them there and keep them there until they can function in our communities. If that could be done in a cost-effective, productive way, we could be successful in reducing our jail mental health population. However, Dr. Green and I knew that one of the major roadblocks in the system was the lack of acute bed space at the state mental facility for admissions from the street, hospitals, or our detention center. We also knew that whatever progress we were making with individuals in our in-custody programs was lost once they were released from custody and returned to the same environment that caused their deterioration in the first place.

Dr. Green and the state medical office had been discussing the need for mental health care reform in northern Nevada and had identified the same roadblock we had. Dr. Green explained that the problem lay not with the number of beds available, but the configuration of the acute and chronic care programs at the state. She explained that although there were limited beds in the acute program, there was an abundance of beds in the chronic program. The trick would be to move bed space from one program to the other utilizing the current staffing.

Dr. Green also understood the need to substantially extend the progress made in our facility. We discussed a long-term goal of providing jail releases a direct pipeline to comprehensive mental health services, a greater amount of medications, and a stable environment in the form of housing and programs. We also discussed that many of these programs were already being accessed by the state mental health system, and that a new type of relationship might help the jail's staff in providing quality discharge planning.

Collaborating on a Comprehensive Plan

Our first formal planning meeting happened within the first month after my conversation with Dr. Green. The State of Nevada and the Sheriff's Office staff solidified our mutual desires to help the mental health population in northern Nevada and came up with a basic "tool chest" of measures the state was willing to provide and which the Sheriff's Office was willing to host.

Washoe County has been utilizing a vigorous and effective mental health court process, but our makeshift team understood that to create a truly effective program, we would need to fully understand the population we were attempting to help. The state requested specific data from the Sheriff's Office regarding names, charges, number of prior bookings, and any previous mental health data available on our mental health inmate population. The data would be used for the sole purpose of mapping the mental health population within the Sheriff's Office—and it did just that. Once a data-sharing agreement was in place, the state was quickly able to identify 100 mentally ill, recidivist inmates served by the Sheriff's Office.

In looking globally at this issue and its impact on numerous aspects of our community, we began using a continuity of care/Sequential Intercept Model[1] [2] for mental health as a tool for providing comprehensive care, effective discharge planning, and comprehensive follow-up to break the cycle of incarceration. This model was introduced to the Forensic Mental Health Team in a comprehensive white paper written by Dr. Ihsam Azzam, the Nevada State Epidemiologist. The Sequential Intercept Model is not the only model available, and the FMHT is constantly looking at better systems to provide the highest quality of care while also doing our absolute best to keep the mentally ill out of our jails and in the mental health system where we all agree they truly belong.

Nevada Mental Health Director Richard Whitley and Dr. Green quickly began working on providing a Psychiatric Case Worker (PCW) for our facility. The goal was to recruit a PCW who currently worked within the Nevada State Mental Health system and the Mental Health Court system, who would be familiar with the population and could provide assistance to our full-time social worker in the jail. This PCW would play an active role in discharge planning but could also provide valuable insight into the cases of mentally ill inmates he or she knew from the state system, where a majority of our inmates had cycled through, in an effort to provide a higher, more effective level of care.

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[1] The Sequential Intercept Model [web page]. National Alliance for the Mentally Ill. *http://www.nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=79159*

[2] Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., "Use of the Sequential Intercept Model as an Approach to Decriminalization of People with Serious Mental Illness," *Psychiatric Services* 57(4), April 2006. *http://ps.psychiatryonline.org/article.aspx?articleID=96593*

By June 1, 2012, the new PCW was in place and working within our facility, assisting our full-time social worker. The social worker had been doing an admirable job working with our inmates on her own for a very long time but did not have the resources at her fingertips that the new PCW had, with her state and regional service referral contacts and her extensive patient knowledge from working within the state psychiatric system.

It is through experience that I say it is at this point, the function of the state-provided PCW should have been developed and communicated effectively to staff at the Detention Center and the state as it became more clearly defined. We did not do this well and we have suffered a bit from it. We experienced two main issues as a result.

- First, our full-time social worker had her own tried and true methods of contacting, assessing, and placing our inmates. When we introduced the state PCW into the system, we did not outline the current procedures and then assist in the integration of other methods. This caused friction between the two staff members as they struggled to define their roles in this new system while at the same time helping us define the role of the program as a whole.

- Our second issue was, and to some extent remains, that the jail's contracted medical providers believe that the state has an ulterior motive for inserting their staff into our system. While some at the state may believe that all mental health services should be provided at the state level, the goal of this team could not be further from this belief. The goal, as stated earlier, is to provide quality mental health services to our specific population as well as continuity of care and transition planning upon release.

My suggestion for agencies attempting this type of state and local partnership is that you first, utilizing representatives from all of your stakeholder groups and partner agencies, clearly define the goals and objectives of your project. You must then clearly define your current system, if one exists. Lastly, it is critical that you sit down with current staff and state-provided management and staff to clearly communicate your goals and objectives as well as to create a work flow that will assist you in meeting your combined goals and objectives.

Results to Date

Within the first 3 months of this unique collaborative effort, the Forensic Mental Health Team had focused on the 100 core mentally ill, recidivist inmates who had been identified at the outset. Among these inmates, 25% had either been introduced into our new system or were on a waiting list for assistance. The state soon provided three full-time program coordinators to work with this population in the community as well as providing a Clinical Program Manager.

Prior to implementation of the FMHT, our contracted medical providers had been releasing these inmates with a 3-day supply of medication, a policy based on cost. Three days' worth of medications is

not sufficient to keep the participants on track until follow-up care can be provided. The state now provides each participant with 14 days of medication, which gives ample time to set up care upon release.

Program Coordinators also have begun utilizing housing provided by non-profit organizations to house our participants. The Program Coordinators ensure participants take their medications and assist them in daily tasks such as attending doctor appointments, shopping, etc. County Social Services, which was already collaborating with the Sheriff's Office on a serial inebriant program, was invited to our team meetings and became closely involved by volunteering to partner with the state to locate additional housing.

The state had initially determined that the cost of providing such services would be approximately $1,100 per inmate per month. This has recently been recalculated, now that the state has realized the severe level of mental illness we deal with on a daily basis in our detention center. The new cost estimate is between $2,000 and $4,000 per inmate per month. Though there was an increase in the cost of medication when the state boosted the amount of medication dispensed on release from 3 days to 14, the primary catalyst for this cost increase is housing. Recently, a local non-profit organization has committed to renovating a current property in an effort to provide additional housing for our participants, and renovation is underway. The State of Nevada is also in the planning phase of utilizing current space within the state system as additional housing as well. The state-provided space is in an unused building on state land that will be used specifically for our type of participant.

Currently, 42 participants are being assisted by the FMHT, with another 20 on a waiting list. The model created through this collaborative effort is now the model being used across the State of Nevada. We are now receiving calls from the state prison system asking if the team could assist their population as well.

Fine-Tuning the System

Monthly meetings of the FMHT, facilitated by the Sheriff's Office, identify deficiencies within the process and heighten communication between all of the stakeholders. Updates about the FMHT also are a regular addition to the agenda at a quarterly meeting of elected state and local officials, court personnel, county management, county social services, and various law enforcement agencies that focus on streamlining court and detention services. The feedback from this group is positive and validates that the goal of curbing recidivism within the mental health prisoner population is being achieved.

We are currently in the process of collecting empirical data on our success in curbing recidivism utilizing this program. A Mental Health Court Justice recently stated she had seen a significant drop in the number of cases her court had been handling on a repeat basis. Our data collection will include the number of bookings for our current population 1 year prior to the program, the number of bookings

since being introduced into the program, the number of bed-days saved, average length of stay, cost per inmate while in the program, and hard dollar savings to the citizens of our county.

A suggestion for other agencies that are developing new strategies in this area is to immediately begin collecting statistics on the number of inmates in your program, the number of bookings for each inmate over a specific period of time, bookings subsequent to the inmates entering into the program, the number of bed-days saved, etc. By collecting this data at the outset, you will certainly be ahead of the game when asked by interested parties to legitimize your program.

Our Forensic Mental Health Team model is by no means complete; we are routinely identifying additional needs of our specific population and developing responses to meet those needs. I am presenting this system and process development as an effective alternative to the reactive system that is in place in many jurisdictions across our nation—a system in which recidivism and substandard mental health treatment is commonplace due to lack of funding, insight, and cooperative action.

About the Author

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Document available at:
http://community.nicic.gov/blogs/national_jail_exchange/archive/2013/03/27/a-country-in-crisis-launching-a-county-state-collaborative-forensic-mental-health-team-an-enhancement-of-the-sequential-intercept-model.aspx